

Missouri Health Insurance Pool Affirmation Form

Please read carefully and sign below.

Name of Applicant: _____
(please print)

I hereby apply for Missouri Health Insurance Pool (MHIP) coverage, as offered by the state of Missouri. I understand and agree to everything listed below:

- I certify that all the information I provided on my application is true and complete. I understand that my MHIP membership can be canceled retroactively to the effective date of coverage if it is later found that I provided any false or incomplete information on this application. Then I must repay any benefits that I was not entitled to receive.
 - I will pay monthly the dues billed by MHIP for the benefits that I requested.
 - If my dues are not paid within 10 days after the due date, my MHIP coverage will end as of the date payment was due.
 - I authorize and direct any physician, dentist, hospital, clinic, medically related facility or other provider of health care services or supplies to release to the Administrator all necessary information about my care for the purposes of underwriting my coverage and providing benefits. In addition, I authorize the Administrator to release information about my medical care in order to comply with state, federal or national accrediting body standards or for research purposes or for the purpose of measuring, assuring and/or improving the quality of my medical care.
 - I understand that MHIP program benefits may not be payable during the 12 months after coverage is effective, for any health conditions, or signs of symptoms thereof, that were known, diagnosed or treated during the six months preceding the coverage effective date. I understand that MHIP will notify me upon approval of my application as to whether this 12-month waiting period will apply to my MHIP benefits for such conditions.
 - I have attached copies of two written proofs of Missouri residency (e.g.; electric bill, gas bill, driver's license).
 - I have enclosed an original document issued to me within the past 60 days by a duly licensed Missouri health insurance company, terminating my coverage for reasons other than fraud or nonpayment of premium; or I have enclosed an original billing statement from a duly licensed Missouri health insurance company.
 - I agree that MHIP may use any reasonable means to investigate and verify the information I have provided in this application.
 - I understand that this is an application only. I will be notified in writing if I am accepted into the MHIP program. I should not cancel any existing health care coverage before I receive this notice.
 - I understand that I must initial and date any changes I make while I am completing my MHIP application.
 - I understand that my coinsurance amount will increase to 50% of eligible expenses if I receive covered care from non-network providers, urgent care outside Missouri or emergency services outside Missouri from a provider other than a hospital emergency room or ambulance provider. These expenses will not apply toward the annual Coinsurance Maximum.* I will also be responsible for obtaining Precertification and Recertification from the Certification Center for any inpatient care, outpatient surgery, home health care or skilled nursing facility care.
- *Exception: I understand that if I receive covered services from a health care provider outside Missouri, my coinsurance amount will be the same as if I had received the services from a network provider, as long as the care has been authorized in advance by the Administrator and the Administrator has determined that the care is not available in Missouri.*
- I will let MHIP know if and when I am no longer eligible for MHIP coverage because of a change in residence, or if I become an inmate of a public institution or because of enrollment in Medicare Parts A and B or eligibility for Medicaid or other health care coverage.

(Note to parents/legal guardians: If your child is under age 18 and is applying for his/her own membership, please sign as indicated below to show your consent and indicate your relationship to the applicant.)

X _____ X _____ X _____
(Applicant's Signature if Age 18 or Older/
Parent's or Legal Guardian's Signature
if Applicant is under Age 18) (Date) (Relationship to Applicant)

X _____ X _____
(Signature of Witness) (Date)

Applicant: After signing, please keep the yellow copy for your records.